

Cafeteria Plan Advisors, Inc.
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Braintree, MA 02184

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AUTHORIZATION FOR PRE-TAX PAYROLL REDUCTION

SIGNED FORM MUST BE RETURNED BY:

New Hire: Within 30 days of Employment

Open Enrollment: Submit by April 30, 2022

Return form to the Benefits Coordinator, Room 114

Name: _____

Employer: **Town of Walpole**

Address: _____

Division: _____

Town Plan

Year: **7/1/2022 - 6/30/2023**

School Plan

Year: **9/1/2022 - 8/31/2023**

(there is a 60 day grace period to spend down funds after plan year ends)

Home Phone: _____

E-Mail Address: _____

SSN: _____

I am a: Town Employee

☐

Deductions will be taken weekly for 50 pay periods

I am a: School Employee

☐

Deductions will be taken over 20 pay periods (September 2022 through June 2023 payroll check)

Benefits Selected:

<input type="checkbox"/>	FSA Medical/Dental Care Account (\$2,850 maximum) (Medical/Dental plan includes Debit Card)	I elect to Contribute \$ _____ for the Plan Year.
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<input type="checkbox"/>	FSA Dependent Care Account/Daycare (\$5,000 maximum) (Requires Dependent Care Certification form)	I elect to Contribute \$ _____ for the Plan Year.
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Direct Deposit Information: (REQUIRED, if not on file with Cafeteria Plan Advisors, Inc.)

I hereby authorize Cafeteria Plan Advisors, Inc. to deposit my claim reimbursements directly to my bank. I also authorize drafts to adjust any over deposits that were credited to my account. I will contact CPA, Inc. immediately with any bank information changes.

Name of Bank: _____ [] Checking [] Savings

Account Number: _____ Routing Number (9 digits): _____

I hereby authorized a salary reduction for the amount(s) shown above. I understand that:

- * This election cannot be revoked or changed during the plan year without a qualifying event as defined in the IRS regulations.
- * Dependents must qualify under regulations set forth by the IRS.
- * Services must be consistent with allowable medical deductions under the IRS Code.
- * Failure to return this signed form to the Benefits Coordinator by the deadline will result in termination from the plan.
- * If you or your spouse are "contributing" to a Health Savings Account (HSA), you are NOT ELIGIBLE for the FSA Health Care Account

Signature: _____

Date: _____